Clinical Policy: Aztreonam (Cayston)

Reference Number: CP.PHAR.209
Effective Date: 05.01.16
Last Review Date: 08.26
Line of Business: HIM/ICHRA, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Aztreonam (Cayston®) is a monobactam antibacterial.

FDA Approved Indication(s)

Cayston is indicated to improve respiratory symptoms in cystic fibrosis (CF) patients with *Pseudomonas aeruginosa*.

Limitation(s) of use:

- Safety and effectiveness have not been established in pediatric patients below the age of 7 years, patients with forced expiratory volume in one second (FEV_1) < 25% or > 75% predicted, or patients colonized with *Burkholderia cepacia*.
- To reduce the development of drug-resistant bacteria and maintain the effectiveness of Cayston and other antibacterial drugs, Cayston should be used only to treat patients with CF known to have *Pseudomonas aeruginosa* in the lungs.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Cayston is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Cystic Fibrosis (must meet all)**:**

1. Diagnosis of CF;
2. Prescribed by or in consultation with a pulmonologist, infection disease specialist, or an expert in treatment of cystic fibrosis;
3. Age ≥ 6 years;
4. *Pseudomonas aeruginosa* is present in at least one airway culture;
5. Member meets one of the following (a or b):†

   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395

   a. Failure of inhaled tobramycin (Kitabis® Pak, TOBI®, and TOBI® Podhaler™ are preferred) unless contraindicated or clinically significant adverse effects are experienced;

      **Prior authorization may be required for inhaled tobramycin*

   b. Antibiotic susceptibility testing indicates that aztreonam would be more effective than tobramycin;

6. If Cayston is prescribed concurrently (or for alternating use) with inhaled tobramycin (Bethkis®, Kitabis Pak, TOBI, TOBI Podhaler), documentation supports inadequate response to either agent alone (e.g., deteriorating pulmonary status, recurrent pulmonary exacerbations);
7. Dose does not exceed 225 mg per day administered on a 28 days on/28 days off cycle.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace/ICHRA and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace/ICHRA and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace/ICHRA and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Cystic Fibrosis (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy as evidenced by reduction in respiratory symptoms (e.g., cough, wheezing, sputum production, or pulmonary exacerbations due to *Pseudomonas aeruginosa*);
3. If Cayston is prescribed concurrently (or for alternating use) with inhaled tobramycin (Bethkis, Kitabis Pak, TOBI, TOBI Podhaler), documentation supports inadequate response to either agent alone (e.g., deteriorating pulmonary status, recurrent pulmonary exacerbations);
4. If request is for a dose increase, new dose does not exceed 225 mg per day administered on a 28 days on/28 days off cycle.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace/ICHRA and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace/ICHRA and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace/ICHRA and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – HIM.PA.154 for health insurance marketplace/ICHRA and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CF: cystic fibrosis
FDA: Food and Drug Administration
FEV_1: forced expiratory volume in one second

Appendix B: Therapeutic Alternatives

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
inhaled tobramycin (Bethkis, Kitabis Pak, TOBI, TOBI Podhaler)	Inhalation solution (Bethkis, Kitabis Pak, TOBI): 300 mg inhaled BID for 28 days (followed by 28 days off tobramycin therapy) Inhalation powder (TOBI Podhaler): 112 mg (4 capsules) inhaled BID for 28 days (followed by 28 days off tobramycin therapy)	Solution: 600 mg/day Powder: 224 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): known allergy

- Boxed warning(s): none reported

Appendix D: General Information

- Aztreonam is recommended for chronic use in both mild and moderate-to-severe disease per the American Thoracic Society 2013 CF guidelines. Severity of lung disease is defined by FEV_1 predicted as follows: normal, > 90% predicted; mildly impaired, 70-89% predicted; moderately impaired, 40-69% predicted; and severely impaired, < 40% predicted.
- The use of continuous alternating therapy (i.e., alternating different inhaled antibiotics in order to provide continuous therapy) lacks sufficient evidence. The efficacy of this practice was evaluated in a randomized, double-blind, phase 3 trial. 90 patients received 28-days inhaled tobramycin alternating with either 28-days inhaled aztreonam or placebo. Although the study found reduced exacerbation and respiratory hospitalization rates with the alternating tobramycin/aztreonam regimen compared to tobramycin/placebo, it was underpowered, and these results were not statistically significant.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CF	One dose (one single use vial and ampule of diluent) inhaled TID for 28 days (followed by 28 days off Cayston therapy)	225 mg/day

VI. Product Availability

Vial: 75 mg

VII. References

1. Cayston Prescribing Information. Foster City, CA: Gilead Sciences, Inc.; November 2019. Available at: https://www.gilead.com/~/media/files/pdfs/medicines/respiratory/cayston/cayston_pi.pdf?la=en. Accessed April 9, 2026.
2. Mogayzel PJ, Naureckas ET, Robinson KA, et al. Cystic fibrosis pulmonary guidelines: chronic medications for maintenance of lung health. Am J Respir Crit Care Med. 2013; 187(7): 680-689.
3. Flume PA, Clancy JP, Retsch-Bogart GZ, et al. Continuous alternating inhaled antibiotics for chronic pseudomonal infection in cystic fibrosis. J Cyst Fibrosis. 2016; 15(6): 809-815.
4. Kapnadak SG, Dimango E, Hadjiliadis D, et al. Cystic Fibrosis Foundation consensus guidelines for the care of individuals with advanced cystic fibrosis lung disease. *J Cyst Fibros* 2020 May;19(3):344-354. doi: 10.1016/j.jcf.2020.02.015.
5. Castellani C, Duff AJA, Bell SC, et al. ECFS best practice guidelines: the 2018 revision. J Cystic Fibrosis. 2018 March;17(2):153-178.
6. Cystic Fibrosis Foundation: Clinical Care Guidelines. Available at: https://www.cff.org/medical-professionals/clinical-care-guidelines. Accessed April 24, 2026.

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J7699	NOC drugs, inhalation solution administered through DME

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Template changes applied to other diagnoses/indications and continued therapy section.	10.03.22	
1Q 2023 annual review: no significant changes; consolidated Legacy Wellcare initial approval duration from 12 months to 6 months consistent with standard Medicaid initial approval duration; references reviewed and updated.	10.06.22	02.23
3Q 2023 annual review: updated prescriber restriction to include "expert in treatment of cystic fibrosis" to align with other policy for inhaled antibiotic (e.g., tobramycin) targeting *Pseudomonas aeruginosa* in CF; references reviewed and updated.	05.05.23	08.23
3Q 2024 annual review: for initial criteria, added Kitabis Pak to list of preferred tobramycin inhalation agents; references reviewed and updated.	05.09.24	08.24
3Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.	04.09.25	08.25
3Q 2026 annual review: no significant changes; for initial therapy, updated approval duration from 6 months to 12 months for chronic therapy; references reviewed and updated. Added ICHRA line of business	07.08.26	08.26

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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